Renal Clinic Referral

This form and any additional information/results can be faxed to (03) 9347 1420

Patient details

Name: ____________________

Address: ____________________

Date of Birth: ____________________

Preferred name/s: ____________________

Phone: __________ Work: __________

Sex: ☐ Male ☐ Female

Mobile: ____________________

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Email: ____________________

Alternative Contact: ____________________

Period of referral: ☐ 3 months ☐ 12 months ☐ Indefinite

Preferred language is: ____________________

DVA Number: ____________________

Pension Card Number: ____________________

Insurance: ____________________

Medicare Number: ____________________

Consent to referral and sharing of relevant information: ☐ Yes ☐ No

Needs interpreter ? ☐ Yes (please specify)………………………………………… ☐ No

Reason for patient referral

Other notes (e.g. past medical history)

Investigations

Blood work (Urea/creatinine/eGFR/Potassium)

Urine (protein ? blood ? – urine albumin creatinine ratio or protein creat ratio preferred)

Imaging (eg Ultrasound renal tract)

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The Royal Melbourne Hospital

Examination findings (if relevant)

Height:

Weight

Current Medication

Allergies

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Referring Physician:

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This form can be downloaded from https://www.thermh.org.au/health-professionals/clinical-services/nephrology

Office Use Only:

Date Received: Date first contacted:

Version 1.2 - Reviewed April 2019